



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

MEDICAL EQUIPMENT DEVICE SPECIALISTS  
7950 DUNBROOK RD  
SAN DIEGO CA 92126

#### **Respondent Name**

LIBERTY INSURANCE CORP

#### **Carrier's Austin Representative Box**

Box Number: 01

#### **MFDR Tracking Number**

M4-11-4150-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Liberty Mutual has failed to respond as to why every patient falls under xe20, and failed to identify which of the three denial reasons was the applicable one for each respective patient that was denied."

**Amount in Dispute:** \$2,547.76

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "DME charges in dispute were denied because they are outside of the ODG and the required preauthorization was not requested. The equipment itself was denied as not medically necessary or necessity was not established either in the ODG or through preauthorization."

**Response Submitted by:** Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30504

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2009 through June 25, 2010	DME Equipment and Supplies	\$ 2,331.76	\$0.00
July 20, 2010, August 20, 2010, September 20, 2010	DME Supplies – HCPCS Code A4595	\$216.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated July 29, 2010; August 20, 2010; September 17, 2010; October 14, 2010; :
  - XE20 – These services were delivered for a non-authorized DME device. The DME provider failed to obtain pre-authorization or the DME device was deemed inappropriate for the work related injury, by extension all related supplies lack the requisite authorization as well and are not separately reimbursement.

### **Issues**

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

### **Findings**

1. The requestor filed a dispute with Medical Fee Dispute Resolution section at the Division on July 14, 2010. This dispute contained dates of service that were not submitted in accordance with 28 Texas Administrative Code §133.307(c)(1)(A). The dates of service that were not submitted timely are September 15, 2009 through June 25, 2010. These dates of service are not eligible for review by Medical Fee Dispute Resolution.
2. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date.
3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307

### **Conclusion**

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

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Signature

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Medical Fee Dispute Resolution Officer

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December 05, 2011  
Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**